PSYCHOLOGY CASE RECORD

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Diploma in Psychological Medicine Examination 2007

By

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CERTIFICATE

This is to certify that this Psychology Case Record is a bonafide record of work done by **Dr. K. B. RAVI KUMAR** during the year 2005-2007. I also certify that this record is an independent work done by the candidate under my supervision.

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CONTENTS

CASE RECORD-I

Name	**:**	A.S.
Informants	**:**	Wife
Age	**:**	38yrs
Sex	**:**	Male
Education	**:**	Dip. M.E
Occupation	**:**	Nil
Marital status	**:**	Married
Reliability	**:**	Good

Presenting Complaint:

Not interested in work, distressed in the mind, decreased sleep.

Duration: 4years

Mode of Onset : Insidious

Precipitating Factors: Nil.

History of Presenting Illness:

Apparently well prior to four years, when he returned from Singapore because he could not cope with the job there. At home he exhibited disorganized behavior like wandering about places, assaulting wife without provocation or explanation, and appearing

preoccupied. He did not initiate conversation with people and did not want to work. His sleep was disturbed on most days when not on medication.

Past medical History : Nil

Treatment History:

Over the last 4years has he has been treated with adequate doses of anti depressants, however compliance has been doubtful. Since the last 3months been on 20mg of T.Olazapine.

Family History:

Born of a non consangious union, 5^{th} of 7 siblings. There is history of suicide in father and continuous psychotic illness in elder brother on treatment with antipsychotics.

Premorbid Personality: Introvert, hardworking and responsible individual.

Physical E**xamination:** Well within normal limits.

Mental Status Examination:

He is moderately build and nourished. Higher mental functions were intact. Thought process was normal in form and stream. Content revealed odd ideas in pictorial representations without any explanation. There was no perceptual abnormality. Affect was restricted. Intelligence was average and lacking in insight into his behavior.

Differential Diagnosis:

Undifferentiated schizophrenia

Severe Depression with psychosis

Tests Administered:

1. Object Sorting Test
2. Thematic Apperception Test
3. Rorschach
4. Sack's Sentence Completion Test
5. Draw a Person test

He scored 45 in BPRS rating scale.

Rationale for Psychological Testing:

The OST was done to study thought process, concept formation and abstract thinking.

The TAT was given to evaluate the patient's level of psychopathology to understand his interpersonal relations and personality.

The Rorschach was administered to find details of psychopathology and psychodynamics.

The SSCT was to evaluate the patient's adjustment in interpersonal relationships and his self-concept.

The DAPT was used to assess personality factors and body image.

Behavioral Observation:

He was co-operative for the test, but the responses were delayed and less in content. He needed to be prompted to persist in a task. He lacked motivation and interest. Rapport could not be easily established. He was defensive and guarded.

Summary of Test Findings:

Responses were characterized by under productivity and slow mentation as evident from the Rorschach protocol. There is lack of clarity in his thought process. Abstraction is inadequate. He shows difficulty in perceptual organization. Does not have adequate group conformity. Need for affect ional relationship is not well developed. There is difficulty in forming a satisfactory object relation, leading to disturbances in interpersonal functioning.

Aggressive tendencies are evident in his responses. There is a tendency to withdraw from reacting to emotional impact of the environment. Depressive features were not significant. He tends to relate to the world in terms of his own needs and values leading to distortion of reality. His ties with reality are weak.

Assessment reveals the evidence of a psychotic process.

Diagnosis:

Diagnostic psychometry reveals evidence of a psychotic process indicative of a Schizophrenic illness.

Management:

He was treated with adequate dose of Tab.olanzapine as Inpatient for 6weeks.

Wife was educated regarding illness and compliance with supervised drugs.

Patient’s insight improved to a level when he was willing to take the medication.

An activity schedule was made and rehabilitation plans were discussed.

CASE RECORD-II

Name	**:**	P.R
Informants	**:**	Wife, Father-in-law, Colleagues
Age	**:**	39yrs
Sex	**:**	Male
Education	**:**	M .Tech (Automobile Engineering)
Occupation	**:**	Senior Ex. Engineer- Neyveli Lignite Corporation
Marital status	**:**	Married
Reliability	**:**	Good

Presenting complaint: Marital dysfunction, wanting a divorce.

Duration: 9years

Mode of Onset: Insidious.

Precipitating Factors: Nil.

History of Presenting Illness:

Mr.P.R has been married for the last 9yrs; however he is unable to have satisfying emotional and sexual relationship with his spouse. The wife describes him as person who likes to be alone, lacks in emotion and avoids sexual contact. She feels that he has odd behaviors like muttering to self and being socially withdrawn not initiating social

contact with people. There are no clear symptoms of schizophrenia. He has been functioning well in his occupation.

There is no history of any sleep disturbance.

Past History and Treatment History:

There is history of two suicidal attempts in the past following stressful life events. Over the last 7years he had been seen by various psychiatrists and has been treated as schizophrenia with low dose antipsychotics.

Family History:

Born of a non consangious union, 2nd of 3 siblings. There is no history of any neuropsychiatric morbidity in the family. Patient was close to his father, and shared little with the mother.

Premorbid Personality:

Introvert –prefers to be solitary. Emotionally cold and detached. Showed little interest in sexual experience. Always preoccupied in own thought.

Physical examination: Well within normal limits.

Mental Status Examination:

He is moderately build and nourished. Appeared anxious with increased motor activity. Higher mental functions were intact. Circumstantial speech was present. Thought process was normal in form, stream and content. There is no perceptual abnormality Affect was constricted. Intelligence was average and lacking in insight into his behavior.

Differential Diagnosis:

Schizotypal personality disorder.

Undifferentiated schizophrenia.

Aim for Psychological Testing:

During the period of admission no clear symptoms of a schizophrenic illness could be elicited. However patient was observed to be socially withdrawn with occasional muttering to self**.** Clinical differentials were maintained as schizotypal personality disorder and schizophrenia. Psychometry was undertaken to look for underlying psychotic process and confirm diagnosis

Tests Administered:

1. Catell's 16PF
2. Draw a person test
3. Object Sorting Test
4. Thematic Apperception Test
5. Sack's Sentence Completion Test
6. Rorschach

He was rated on BPRS scale, and the score was 25.

Rationale for psychological testing:

Cattell's 16PF was done to assess personality factors under various dimensions.

The DAPT was used to assess personality factors and body image.

The OST was done to study thought process, concept formation and abstract thinking.

The TAT was given to evaluate the patient's level of psychopathology to understand his interpersonal relations and personality.

The SSCT was to evaluate the patient's adjustment in interpersonal relationships and his self-concept.

The Rorschach was administered to find details of psychopathology and psychodynamics.

Behavior observation during testing:

He was co-operative for testing. Attention was adequate and he could persist on any given test for a reasonable period of time. He responded to questions appropriately, however tended to give elaborate answers. He spoke only when spoken to and did not initiate conversation. Eye contact was fair. Mild anxiety was evident. Constricted affect was observed.

Summary of Test findings:

He is a person with fair intellect but lacking adequate adaptive capabilities. His personality is marked by a rigid, inflexible behavior pattern. He is a self-absorbed individual who tends to structure environment according to his values and needs. He tends to focus on the obvious aspects of experience and does not look for relationships among them.

He lacks confidence and has feelings of insecurity. There is a quest for certainty as evidenced in his careful attention to detail. Tends to have a perfectionistic demand on self. An obsessive quality is evident in his behavior. He has several competing ideas about a single event simultaneously and hence has difficulty in conceptualizing the whole situation.

He is inhibited in his productivity under conditions of strong environmental impact. Excessive social anxiety associated with paranoid fears is present. He tends to withdraw from genuine emotional involvement. There is a need to be alone. He feels anxious around strangers. He is imperceptive about nuances of emotional surroundings. There is inability to connect meaningfully or pleasurably with others. He is unable to express himself adequately in social situations. There is a significant disturbance in the sexual area as characterized by his, fearfulness and discomfort in close intimate relationship. Psychosexual immaturity is evident.

He has inability to foresee consequences and makes quick logical decisions that are impractical. In making decisions he depends on others. There is a reluctance to assert self and a lack of zest for life. An eccentric and odd pattern in thought process is evident.

Reality orientation is adequate. Currently a psychotic process is not evident. However, there is significant disturbance in his thought process indicating a maladjusted personality. Findings are suggestive of a probable schizotypal personality disorder.

Diagnosis:

Diagnostic psychometry is consistent with absence of any psychotic process. Assisting in the diagnosis of schizotypal personality disorder.

Management:

Patient was in the wards for 6weeks, during which time the diagnosis was made. They were unwilling to prolong the stay for marital therapy. During the time of admission he was started on low dose antipsychotic, however it was tapered and stopped, as no psychosis was evident. The wife was supported through the admission and educated regarding diagnosis. The couple was offered continued assistance after discharge.

CASE RECORD – III

Name	**:**	R.K
Informants	**:**	Father
Age	**:**	20yrs
Sex	**:**	Male
Education	**:**	Discontinued 12th class.
Occupation	**:**	Nil
Marital status	**:**	**S**ingle
Reliability	**:**	Good

Presenting complaint **:** Feeling that his body is wasted.

Duration **:** 7 years

Mode of onset **:** Insidious

Precipitating factors **:** Nil

History of Presenting Illness:

Apparently well prior to 7 years, since then has repetitive, intrusive irrational thoughts that his body is emaciated and wasted. He would constantly look into the mirror each time he had this thoughts. He also had obsessive rumination about cricket, about how the shot could be played in different ways. Over the last 7years there has been marked

decline in his scholastic performance with deterioration in self-care and episodes of assault behavior.

Past Medical History: Nil

Treatment History:

Had been diagnosed to have schizophrenia in 1997 and was put on low dose antipsychotic for incomplete duration. In 2002 was seen in NIMHANS and was diagnosed having OCD and was given a trail of Citalopram. In the last two years he has been on various antipsychotic like Risperidone and Olanzapine, however no improvements were noticed.

Family history:

Born of a non consangious union, 3rd of 3 siblings. There is history of depression in maternal uncle and on treatment.

Pre-morbid Personality:

Introvert, reserved individual who liked to watch cricket.

Physical E**xamination:** Well within normal limits

Mental Status Examination:

He is moderately build and nourished. His eye contact was poor and rapport was difficult to establish. Higher mental functions were intact. Speech was not spontaneous and poor in content. Thought process was normal in form and stream. Content revealed

obsessive ruminations regarding his appearance which were irrational and firm but shakable, no delusions were present. There was no perceptual abnormality. Affect was blunt. Intelligence was average and lacking in insight into his Obsessions.

Differential Diagnosis:

Obsessive-compulsive disorder.

Delusional disorder-Body dismorphic type.

Aim of Psychological Testing:

To clarify diagnosis regarding any underlying psychotic process in psychopathology.

Tests Administered:

1. Multiphasic Personality questionnaire.
2. Thematic Apperception Test
3. Sack's Sentence Completion Test
4. Draw a Person test
5. Object Sorting Test
6. Rorschach

His BPRS rating score was 30

Rationale for Psychological Testing:

The MPQ was done to identify the personality traits.

The TAT was given to evaluate the patient's level of psychopathology to understand his interpersonal relations and personality

The SSCT was to evaluate the patient's adjustment in interpersonal realationships and his self-concept.

The DAPT was used to assess personality factors and body image.

The OST was done to study thought process, concept formation and abstract thinking.

The Rorschach was administered to find details of psychopathology and psychodynamics.

Behavioral Observation During Testing:

On observation he was fairly alert, attentive with no evidence of distractibility. He was occasionally noticed to be preoccupied. He was casually dressed and groomed. Eye contact was appropriate. Primary mental functions were intact. Rapport could not be easily established; however he was cooperative for the assessment procedures. He appeared to be dull and anxious. Reaction time was delayed. Speech was appropriate but slow with low tone.

Summary of Test Findings:

He is a person of fair intellect, lacking adequate resources for creativity and imagination. His personality is characterized by strong dependency needs, fearfulness and anxiety. He has feelings of inferiority, low self-esteem and lack of confidence, which is partially reflected, in his preoccupation with his body image. He tends to mask his distress and feelings of inadequacy by aiming for unachievable goals. His failure to attain these goals has led to frustration and anger which he directs towards self and others. In addition he is distressed at his inability to satisfy parental and societal expectations leading onto feelings of helplessness and worthlessness.

Adjustment difficulties and poor interpersonal relationships are evident. He lacks adequate social and adaptive skills. His emotional control is poor and he tends to displace anger onto others. He tends to use an emotional coping style.

Assessment reveals a slow mentation with poverty of content. Reality orientation is fair and he shows partial insight as evidenced by his ability to identify specific stressors that could have precipitated his problem. There is no gross abnormality of thought. However, there are indications of inner tension, anxiety, a predominant negative self-image and preoccupation with body image. Marked depressive features are present. No psychotic process is evident.

Final Diagnosis: Severe depression without psychosis

Management:

He was started on C.Flouoxtine 20mg and dose gradually improved to 60mg.He showed significant improvement in his depressive cognitions and obsessive ruminations. His BPRS score had reduced from 30 to 7 at the time of discharge.

Patient and family were educated regarding the illness its course and prognosis. An activity schedule was made with the help of patient and review was planned after 6months.

CASE RECORD-IV

Name	:	S.B
Age	:	21 Years
Sex	:	Female
Education	:	Up To 4th Class
Religion	:	Hindu
Marital Status	:	Single
Informant	:	Parents
Reliability	:	Good

Chief Complaints:

Inadequate speech development.

Poor scholastic performance.

Duration: Since childhood.

History of Presenting Illness:

Ms. S.B has had difficulty with academics since the beginning of schooling. She also had history of not persisting with tasks and needing constant supervision and prodding to complete tasks. For the last two years since the birth of her younger brother she has been noticed to be more irritable and adamant for minor problems. She is also slow to walk and takes longer to do simple tasks. There was no history of lack of social reciprocity and pronominal reversal. She continued to play with children much smaller than her age in spite her growing up. He had no sleep disturbances. No history to suggest psychosis. There was no history of seizures, loss of consciousness or altered sensorium.

Past History: Nil

Family History:

She was born of a non-consanguineous union. She was the first child to her father who was 28 years working as a farmer and mother aged 22 years who was a housewife. She was being cared for by her parents. There is no history of mental retardation, other neuropsychiatric morbidity or significant medical illness.

Personal Birth and Development History:

She was born at term by a normal home delivery. Her mother had no infections or drug intake or bleeding during the pregnancy. She had been vaccinated according to schedule and had no delayed labour. She was 1.5kg and cried feebly after birth. She was pink at birth. There was no history of suckling difficulty. There was no history of jaundice or seizures postnatally. She gained weight adequately and was immunized according to protocol. She was weaned off breast milk from her 8^{th} month onwards. She had achieved head control by 6 months, turning to side by 8 months, sitting without support by 12 months, standing by 14months and walking by 24 months. She developed first word by 2 year of age, two words by 5 years and sentences by 7 years.

Currently she can communicate her needs verbally but cannot speak fluently a. She enjoys doing small household works and helping mother in the kitchen.

In self help she is independent for food. She is totally independent in toilet care and bathing. She has age appropriate sense of modesty.

She attended school until 4^{th} class during which time she had to discontinue because she was not able to perform adequately.

Physical Examination:

Epicanthal folds and low set ears present, no other facial dysmorphism observed.

Pulse 100/min; BP 120/70;

There was no pallor, icterus or lymphadenopathy.

CVS – S1 S2 heard in all areas. No murmurs.

RS – bilateral air entry equal. No adventitious sounds.

Abdomen – No organomegaly.

Nervous system – grade 5 power all limbs.

Mental Status Examination:

She was a moderately built and adequately kempt. Made eye contact but did not maintain. Rapport was established with difficulty. She was easily distracted with a brief attention span and poor concentration. Her primary mental functions were grossly intact. No gross psychopathology was detected.

Provisional Diagnosis: Unspecified Mental Retardation.

Rationale for Psychometry:

Psychological assessment was done to clarify the presence of a compromised intelligence in view of history of delayed language, poor scholastic performance and plan for appropriate intervention and rehabilitation.

Tests Administered:

1. Vineland's Social Maturity Scale.(VSMS)
2. Binet-Kamat Test.(BKT)

Rationale for Individual Test:

1. VSMS measures social adaptive behaviour across different domains.
2. BKT is based on the Stanford Binet Test and standardized for Indian population. It has been widely used for assessing the level of mental retardation.

Behavioural Observations:

She was a well cooperative adult obeyed the instructions given to her. Her attention could be aroused but at times she needed reminders to continue the tasks given. At times she was noticed to be fidgety and seeking reassurance from her parents.

Test Findings:

1. **VSMS** – Break up score is as follows;

Self help General	= 7.85
Self help Dressing	= 7.35
Self help Eating	= 6.43
Self Direction	= 4.83
Communication	= 2.23
Socialization	= 3.75
Locomotion	= 4.23
Occupation	= 5.13

Overall social maturity is around 11years level with a social quotient of 71.

2. **BKT:**

Basal age:	4 years
Terminal age:	8 years
Language ability:	6 years

Meaningful memory: 5 years

Non-Meaningful memory: 7 years

Conceptual thinking: 7 years

Nonverbal thinking: 6 years

Numerical reasoning: 3 years

Visuo-motor: 5 years

Social intelligence: 5 years

Mental age: 6years and 8 months; IQ: 76.

Summary of Test Findings:

The test revealed an IQ of 76 on BKT and SQ of 71 on VSMS, which is indicative of Borderline intelligence.

Management Plan and Goals:

1. Inpatient management.
2. Self-care and ADL training to promote self-dependence.
3. Special education and behavioural modification techniques for concepts, language, communication and arithmetic.
4. Parental counseling and support regarding skill deficits to improve understanding, acceptance and reduce unrealistic expectations.

CASE RECORD-V

Name	:	SD
Age	:	56yrs
Sex	:	Male
Marital Status	:	Married
Education	:	B.A
Occupation	:	Business
Informants	:	Wife
Reliability	:	Fair

Chief Complaints:

1. Forgetfulness
2. Irritability and anger outbursts
3. Disinhibited behavior

Duration of the Illness: 5 years

Onset: Insidious

Precipitating Factor: Nil

History of Presenting Illness:

Patient was apparently well up till 5 years back. He had been working as a police officer. Since the last 5years he had been noticed to be irritable with frequent angry outbursts. He would be very emotional and cried when speaking of subjects of spiritualism. His wife identified that he would frequently lose his belongings when he

came home from duty, for the last 3years.For the last one and half year he was not able to do simple calculations while shopping and would forget the way about home. His handwriting has been gradually deteriorating over the last one year, almost illegible for the last 6months.In the last 4months he has been incontinence in urination and passing stools in inappropriate places. His sleep has been disturbed for the last 2years.

Past History and Treatment History: Nil.

Family History:

The patient is the eldest among the five siblings. There is no family history of Dementia depression substance use and other neuropsychiatric morbidity.

Education History:

The patient was an average student in his school days. He graduated in arts, When after he had undergone police training.

Premorbid Personality:

He is described to be a hardworking, enthusiastic individual who is having a well balanced premorbid personality. Occasionally he consumes alcohol in the company of his friends.

Physical Examination:

General examination and systemic examination were within normal limits there was Frontal lobe release signs present, no other localizing signs or neurological deficits.

Mental Status Examination:

Patient was a well built and adequately groomed. There were no motor abnormalities. During the interview the patient was alert and conscious. Attention could be easily aroused but was not sustained adequately. Attention span was found to be poor as he was not able to perform the serial subtraction test correctly. His registration was adequate but the recent and the remote memory were impaired. He was grossly oriented to time, place, person and the immediate environment. His speech was audible and at times loud, with increased reaction time and normal productivity. The manner of speech was excessively relaxed with perseveration. Sample of speech revealed no impairment in the form and the stream of thought. Poverty of content of thought was noticed. Cross section ally, no delusion could be elicited. He denied any perceptual abnormalities. His mood was euthymic with occasional labile affect.

There was no suicidal ideation, compulsive phenomenon or volitional abnormalities. He was having partial insight into his illness with impaired personal and social judgment.

Aim of Assessment:

Neuropsychological tests were administered to evaluate the cognitive profile of the patient in order to address the rehabilitation issue.

Tests Administered:

1. Bender Gestalt Test (BGT)
2. NIMHANS Neuro Psychological Battery
3. Mini Mental Status Examination (MMSE)
4. PGI Memory Scale.

Rationale of the Tests:

- To make a cognitive profile
- To find areas of deficits
- To guide the patient to get the vocational rehabilitation

1. Bender Visuo-motor Gestalt Test (BGT) is designed to measure Visuo perceptual difficulties. It is also a good test to introduce the patient to the testing situation. It is usually used to differentiate organic illness from a functional illness.
2. NIMHANS- Neuropsychological Battery by Dr C. R. Mukundan was administered to the patient to tests the subject's performance across the various lobe functions. It has been especially designed to suit Indian patients. It comprises of a series of tests for assessing the lobe functions of the brain.
3. Mini Mental Status Examination: Screening test to find out cognitive impairment.
4. PGI Memory Scale: To test memory and cognitive functioning and other domains.

- Frontal Lobe:

  Attention, scanning, ideational fluency, abstraction, delayed response – learning, execution of motor task.

- Parietal Lobe :

  Perceptual Gestalt (Bender Visuo-motor gestalt test), visual analysis and synthesis (Block Design Test), test for spatial relations and test for parietal lobe focal signs.

- Temporal Lobe :

  Sentence repetition, comprehension, visual learning and memory, visual integration (Object assembly test), visual memory (Benton's Visual retention test) & visual learning memory test.

General Behavioural Observation:

S.D had been cooperative, attentive, at the time of assessment. However he was mildly distractible and was lacking confidence when the complexities of the tests were increasing. So the testing was done in different sittings to avoid the distraction.

Test Findings:

Frontal Lobe:

Personality changes: disinhibition, mild irritability and apathetic with unconcern attitude was noticed.

Attention: patient was attentive and arousal was spontaneously.

Trail making test was impaired indicating deficit in simple mental shifting.

Digit cancellation: impaired

In Digit Symbol test there was moderate delay in speed of performance.

He was found to have poor working memory as he had sever difficulties in digit backward test and simple verbal arithmetic test.

Expressive speech was spontaneous and with perseveration.

No significant impairment in Ideational fluency and verbal fluency

Planning for BGT: planning was fair for the test, Motor persistence was adequate.

Visio spatial planning was adequate.

Maze test: was normal indicating no significant impairment in planning and Visio motor organization.

Stroop Colour Word Test: this test is usually done to find out distraction to visual stimuli. Test result showed severe impairment in Stroop Test as he was repeatedly making errors in finding the correct co lour.

Parietal Lobe:

Comprehension: He had difficulties in understanding the simple instructions of test even with repetitive prompts and explanations

BGT: There was no crowding and overlapping. The Visio spatial organization was fair. Focal signs in form of dressing apraxia and constructional apraxia & astereognosia were present

Geographical disorientation was present as he was finding it difficult t give the directions of the places of the house where he was living with the help of the relative and the room in the hospital.

Temporal Lobe:

Visual integration test was assessed by block design .He had definite difficulties in complex deigns.

Verbal memory: logical memory or verbal memory had moderate to severe impairment.

Auditory Verbal learning: he got 9 out of 15 recalls, which shows mild to moderate impairment.

In visual Learning memory (PGI Scale) there was mild to moderate impairment.

Impression:

From the above findings it can be concluded that the patient is having global deficits across the lobes the frontal, parietal and temporal lobes.

Diagnosis:

Dementia of Alzheimer's type.

Management:

Pharmacological

Low dose atypical anti psychotic (Quetiapine 25mg) was added for sleep and control of agitation.

Non pharmacological

Psycho education of the patient and relatives about the nature, course, prognosis, and treatment of the illness.

Support and ventilation to the relatives.

Occupational therapy focusing on the ADL.